

Everybody who uses services through United Behavioral Health (UBH) or U.S. Behavioral Health Plan, California (USBHPC) is asked to complete this brief questionnaire. It will help us measure whether the services were helpful in meeting your needs. Please answer each item as best you can, based on how you are feeling today. We encourage you to discuss your answers with your clinician. That way, together you can achieve the best possible results.

We may review your answers to see if we can offer you additional resources or support. We may also review your answers with your clinician if we believe that will help you.

We respect your privacy and confidentiality. Your answers will not be revealed to your employer or health plan.

Your response is very important to us. It is one of the best ways we can understand your concerns and help you get the assistance you need. While we urge you to complete this questionnaire, you are not required to do so. This questionnaire will not affect your eligibility for services through UBH or USBHPC.

If you have any questions about this questionnaire, please call the number on the back of your enrollee identification card.

Your Information (Please print. All fields are required.)

First Name:	<input type="text"/>	Last Name:	<input type="text"/>
Date of Birth:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Subscriber ID:	<input type="text"/>

1. Please indicate the PRIMARY problem that has led you to seek help today.

- | | | |
|--|--|--|
| <input type="radio"/> Depressed mood | <input type="radio"/> Relationship/family problems | <input type="radio"/> General stress |
| <input type="radio"/> Anxiety or worry | <input type="radio"/> Occupational problems | <input type="radio"/> Physical health problems |
| <input type="radio"/> Grief or loss | <input type="radio"/> Substance use problems | <input type="radio"/> Other emotional/psychological problems |

2. How much have the problems which have led you to seek help bothered you in the past 30 days?

Not at all	A little bit	Somewhat	Quite a bit	Extremely
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- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|

3. In the past 30 days, to what extent have the problems which led you to seek help interfered with your:

- | | | | | | |
|-----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a. Family life | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Social life | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Work, schoolwork, or housework | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Health and physical well-being | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

4. Following are U.S. problems or complaints that people sometimes have.

For each problem please indicate how much that problem has bothered or distressed you during the past seven days, including today.

Not bothered	A little bothered	Moderately bothered	Quite bothered	Extremely bothered
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- | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a. Nervousness or shakiness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Feeling lonely | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Feeling sad or blue | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Your heart pounding or racing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Feeling hopeless about the future | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Feeling everything is an effort | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Spells of terror or panic | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Feeling so restless you couldn't sit still | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Feelings of worthlessness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Feeling suddenly scared for no reason | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| k. Feeling no interest in things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Please continue on the next page (1 of 3)

Your Name (please print): _____

	Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
5. Please tell us how much you agree with the following three statements:					
a. I feel good about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can deal with my problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I am able to maintain control over my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Yes		No		
6. Are you currently employed? (If yes, please proceed to question 7 below. If no, please skip to question 11 below.)		<input type="radio"/>		<input type="radio"/>	
7. During the past 30 days, how many days were you unable to work because of your physical or mental health?	<input type="text"/> Days				
8. During the past 30 days, how many days did you work, but had to cut back on how much you got done due to your physical or mental health?	<input type="text"/> Days				
	Yes		No		
9. Are you receiving, have you filed, or are you considering filing for disability benefits or workers' compensation? (Your answers will be kept completely confidential)		<input type="radio"/>		<input type="radio"/>	
10. Are you having any recent problems at work?		<input type="radio"/>		<input type="radio"/>	
11. Are you caring for someone in your family who is ill or disabled?		<input type="radio"/>		<input type="radio"/>	
	Excellent	Very Good	Good	Fair	Poor
12. In general, would you say your health is:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not bothered	A little bothered	Moderately bothered	Quite bothered	Extremely bothered
13. In the past 30 days, how much have you been bothered by physical pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Yes		No		
14. Do you now have a serious and/or chronic medical condition such as diabetes, cancer, heart disease, asthma, or rheumatoid arthritis?		<input type="radio"/>		<input type="radio"/>	
If yes, please indicate the medical condition(s) _____					
	zero	1	2-3	4-5	More than 5
15. In the past six months, how many times have you seen a medical doctor or used other medical services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Yes		No		
16. Have you had a drink or used drugs in the past 30 days? (If yes, please proceed to question 17. If no, please skip to question 23.)		<input type="radio"/>		<input type="radio"/>	
17. In the past 30 days, have you ever felt you ought to cut down on your drinking or drug use?		<input type="radio"/>		<input type="radio"/>	
18. In the past 30 days, have people annoyed you by criticizing your drinking or drug use?		<input type="radio"/>		<input type="radio"/>	
19. In the past 30 days, have you ever felt bad or guilty about your drinking or drug use?		<input type="radio"/>		<input type="radio"/>	
20. In the past 30 days, have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?		<input type="radio"/>		<input type="radio"/>	
21. How many days in the past week did you have a beer, glass of wine, mixed drink, or shot of liquor?	<input type="text"/> Days				
22. On a typical day when you have had a drink, how many glasses, bottles, cans, and/or shots do you drink?	<input type="text"/> (Enter # of glasses, bottles, cans, and/or shots)				

